

# AUTHORIZATION FOR RELEASE OF INFORMATION

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PRINTED NAME: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

I authorize Dr. Karen Horst, whose office is located at the address above, to disclose and/or obtain information from the following physician, hospital, other treatment provider or organization, relative, friend, or any other person I choose to name below:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

By signing below, I acknowledge that the following information may be released, discussed or disclosed. (Instructions: If you agree to the release of all protected health information (PHI), then check the first option. If you want to limit what is released, then choose the option(s) you agree to and check those options.)

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | DISCHARGE SUMMARY                      |
| <input type="checkbox"/> | MEDICATION RECORDS                     |
| <input type="checkbox"/> | MENTAL HEALTH DIAGNOSIS                |
| <input type="checkbox"/> | PROGRESS NOTES                         |
| <input type="checkbox"/> | SUBSTANCE ABUSE INFORMATION            |
| <input type="checkbox"/> | TREATMENT PLAN                         |
| <input type="checkbox"/> | COMPLETE MEDICAL/PSYCHIATRIC RECORD OR |

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Dr. Karen Horst. Unless otherwise revoked, this consent expires in twelve months from this date. I understand that once information is disclosed per my authorization, the information may be re-disclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_